DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
		445116	B. WING			10/20/2021	
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, SMITHVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 825 FISHER AVE SMITHVILLE, TN 37166				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		
F 000	was conducted by the 20, 2021. The facility compliance with 42 regulations and has Centers for Disease (CDC) recommend COVID-19. Total centers for Disease (CDC) recommend COVID-19.	sed Infection Control Survey the State Agency on October ty was found to be in CFR §483.80 infection control is implemented the CMS and e Control and Prevention ed practices to prepare for		TITLE			(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

program participation.

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	445116					10/20/2021		
	PROVIDER OR SUPPLIER		•	825	REET ADDRESS, CITY, STATE, ZIP COD 5 FISHER AVE 1ITHVILLE, TN 37166			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
E 000	completed on 10/20	paredness survey was 0/2021 at NHC Healthcare of ciencies were cited under	E	000				
LABORATOR)	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE		TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: TN2101

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
TN2101		TN2101	B, WING		10/20/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NHC HEALTHCARE, SMITHVILLE 825 FISHER AVE SMITHVILLE, TN 37166						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
N 000	was conducted by t 20, 2021. The facili compliance with inf has implemented the Disease Control and recommended practice.	sed Infection Control Survey the State Agency on October ity was found to be in fection control regulations and ne CMS and Centers for id Prevention (CDC) otices to prepare for COVID-19 0-8-6, Standards for Nursing us 77.	N 000			
Division of Us	ealth Care Facilities					

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

THMZ11